U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 June 2007

CASE NO.: 2006-BLA-5698

In the Matter of

J.V.S.,
Claimant

v.

ARCH OF WEST VIRGINIA/APOGEE COAL COMPANY
Employer

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard J. Stayton, Esq.,
For the Claimant

Christopher M. Hunter, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a miner's subsequent claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on October 1, 2002. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 ("Regulations"), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The current claim is the Claimant's second claim for benefits. The Claimant filed his first claim for benefits on May 22, 1995. (Director's Exhibit ("DX 1")). The District Director issued an initial determination, dated October 17, 1995, in which it denied the claim. Specifically, the District Director found that the Claimant did not qualify for benefits because the evidence did not show that he was totally disabled due to pneumoconiosis.[1] The Claimant contested this decision.

Thereafter, an informal conference was held on April 3, 1996, between the Claimant, Employer, and District Director. Additional evidence was presented at the conference. In a Memorandum of Conference, dated May 23, 1996, the District Director found that the Claimant had CWP and that the disease was caused by coal mine employment but that the evidence did not show that the Claimant was totally disabled by the disease. Thus, the District Director "affirmed" its previous decision.[2]

The Claimant requested a hearing before an Administrative Law Judge, by letter dated June 18, 1996. The Honorable Pamela Lakes Wood scheduled a hearing for January 1, 1997; however, the Claimant failed to either attend the hearing or request a continuance. On February 7, 1997, Judge Wood issued an Order to Show Cause, requiring the Claimant to show why the claim should not be dismissed. On March 25, 1997, Judge Wood issued an Order of Dismissal because the Claimant failed to respond to the Order to Show Cause.

The Claimant filed the current claim on October 1, 2002. (DX 3). On October 3, 2003, the District Director issued a Proposed Decision and Order Awarding Benefits. The District Director found that the Claimant had established the existence of pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he was totally disabled, and that his total disability was due to pneumoconiosis. On October 9, 2003, the Employer disagreed with

[1] The Initial Determination did not separate the issues of total disability and disability causation. However, the accompanying guide for submitting additional evidence, toward the elements of entitlement that Claimant had not yet met, specified how the Claimant could establish both total disability and disability causation. Therefore, I find that the District Director found that the Claimant had not established either the elements of total disability or disability causation in the Initial Determination.

[2] In the Memorandum of Conference, the District Director again did not separate the issues of total disability and disability causation. However, the District Director "affirmed" its previous decision, in which, for the reasons described above, it had found that the Claimant was not totally disabled or that his total disability was due to pneumoconiosis. Therefore, I find that Memorandum of Conference also reflects a determination that the Claimant did not establish total disability or that his total disability was due to pneumoconiosis.

the decision and requested a hearing before an Administrative Law Judge. The Director, Office of Workers' Compensation Programs ("OWCP") referred the claim to the Office of Administrative Law Judges ("OALJ") on January 13, 2004. Two continuances were subsequently granted so that the Claimant could further develop evidence.

On November 11, 2005, The Honorable Stephen L. Purcell granted a third continuance, this time so that the Claimant could obtain a pathology report from Dr. Joshua Perper. In addition to granting the continuance request, Judge Purcell remanded the claim to the District Director for the development of Dr. Perper's report. After the Claimant submitted Dr. Perper's report, the District Director issued a Proposed Decision and Order of Remand, dated February 14, 2006, stating that the claim would be forwarded back to OALJ. On April 28, 2006, the Director, OWCP again transferred the claim to OALJ.

I was assigned the case on August 8, 2006. On January 25, 2007, I conducted a hearing in Charleston, West Virginia, at which the Claimant and Employer were represented by counsel. No appearance was entered for the Director, OWCP. The parties were afforded the full opportunity to present evidence and argument. I admitted Claimant's exhibits ("CX") 1-4 and 6-19,[3] Employer's exhibit's ("EX") 1, 1(a), 4, 5, 5(a), and 6-7,[4] and Director's exhibits ("DX") 1-43, 46-48, 50, and 52-69.[5] Post-hearing, I admit EX 3(b).

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[3] The Claimant proffered as CX 5, a reading by Dr. Smith, which was generated by the Employer and positive for the existence of pneumoconiosis. The Claimant argued that because the Employer generated it and its results were against the Employer's interests, the exhibit should be admitted for good cause. (Transcript ("TR") 11-12). The Employer countered that the Claimant's rationale was insufficient to constitute good cause. I found that no good cause had been established and excluded the exhibit. (TR 14).

Additionally, the Employer objected to the admission of CX 6, Dr. Miller's 3/2 reading offered in rebuttal of Dr. Gaziano's 2/3 reading. Specifically, the Employer argued that Dr. Miller's positive finding cannot rebut Dr. Gaziano's finding, which was also positive. Although sympathetic to the Employer's argument, I overruled the objection based on the Benefits Review Board's holding in *Sprague v. v. Freeman United Coal Mining Co.*, BRB No. 05-1020 BLA (Aug. 31, 2006)(unpub.), which allows for the rebuttal of a positive reading with another positive reading. Therefore, CX 6 is admitted.

Finally, the Claimant proffered exhibits CX 20-29, medical evidence in excess of the evidentiary limitations of 20 C.F.R. § 725.414, for good cause. I found that no good cause existed and excluded these exhibits. (TR 23).

[4] The exhibits proffered as EX 2, 4(a), 8, and 9 contained evidence in excess of the evidentiary limitations of 20 C.F.R. § 725.414. The Employer offered them for good cause. I found that no good cause existed and therefore excluded these exhibits.

The exhibits proffered as EX 3 contained rebuttal of Dr. Aubrey's pathology report, which was submitted as part of a record of treatment. The Regulations do not authorize the rebuttal of treatment records. *See See Henley v. Cowin & Co.*, BRB No. 05-0788 BLA (May 30, 2006). Therefore, EX 3 is excluded. Additionally, the exhibit proffered as EX 3(a) contained rebuttal of Dr. Perper's pathology report, which is admissible, but also referred to the inadmissible rebuttal of the treatment records. Instead of redacting the inadmissible parts of this exhibit, I excluded the exhibit but gave the Employer the opportunity to submit a cured exhibit post-hearing. (TR 42-44). The Employer has done so by submitting EX 3(b).

Finally, the Claimant objected to the admission of EX 5(a), a rebuttal X-ray reading. Specifically, the Claimant argued that he had submitted two readings of one X-ray affirmatively; therefore, the Employer is only allowed one reading of that X-ray in rebuttal. The Claimant pointed to a plain meaning of the Regulations, which state that an employer shall submit "…in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each *chest X-ray*…submitted by the claimant." 20 C.F.R. § 725.414(a)(3)(ii)(emphasis added). As I indicated at the hearing, I find the Claimant's argument appealing. Nevertheless, I am constrained by the Benefits Review Board's decision in *Ward v. Consolidation Coal Co.*, BRB 05-0595 BLA (March 28, 2006), which holds that in this exact situation, the party offering rebuttal may submit a rebuttal reading for each reading submitted

ISSUES

I. Whether the Claimant has pneumoconiosis, as defined by the Act and Regulations?

II. Whether the Claimant's pneumoconiosis arose out of his coal mine employment?

III. Whether the Claimant is totally disabled?

IV. Whether the Claimant's total disability is due to pneumoconiosis?

V. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

VI. Whether the Claimant has any dependents for the purposes of augmentation of benefits?

FINDINGS OF FACT

I. Background

A. Coal Miner

The Claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations for 35 years. (TR 25).

B. Date of Filing

The Claimant filed his claim for benefits on October 1, 2002. None of the Act's filing time limitations are applicable and the matter of timeliness has not been contested; thus, the claim was timely filed. (DX 3).

C. Responsible Operator

Arch of West Virginia is the last employer for whom the Claimant worked a cumulative period of at least one year and is properly designated responsible coal mine operator in this case, under Subpart G, Part 725 of the Regulations. (TR 25; DX 4).[6]

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affirmatively by the opposition, even if both are readings of the same X-ray. Therefore, I overruled the Claimant's objection and admitted EX 5(a) (TR 46-47).

[5] The exhibits proffered as DX 44, 45, 49, and 51 consisted of medical evidence submitted by the Employer in excess of the evidentiary limitations of 20 C.F.R. § 725.414. The Employer argued that they should be admitted for good cause, stating that these exhibits are relative and probative. (TR 7). The Claimant objected to their admission, stating that their cumulative effect does not add anything to the determination. (TR 7). I found that no good cause existed for the admission of these evidence and therefore excluded them. (TR 7).

[6] Additionally, although the Employer had initially contested the issue of Responsible Operator, it withdrew its contest of that issue at the hearing. (*See* TR 9).

D. Dependents

The Claimant has one dependent, his wife, for purposes of augmentation of benefits. (TR 24-25; DX 3).

E. Personal, Employment, and Smoking History

The Claimant was born on September 28, 1937. (TR 24; DX 3). He married his wife on February 21, 1959. (DX 3; DX 11). He testified that he had 35 years of coal mine employment. (TR 25). His last coal mine job was driving a rock truck on a strip. (TR 26). This job primarily entailed hauling rock from the shuttle, although it also involved pulling and lifting cables. (TR 26). The Claimant testified that he worked for seven years on the strip and the rest underground. (TR 27). When he last worked underground, the Claimant was a continuous miner operator. (TR 27). The Claimant ceased coal mine employment in 1991. (TR 28). Finally, the Claimant testified that he never smoked cigarettes or used any other tobacco products.

II. Medical Evidence

A. Chest X-rays

The current claim contains twelve readings of four X-rays that are properly classified for pneumoconiosis pursuant to 20 C.F.R. § 718.102(b).[7] Eleven of these readings are admitted for determining the presence or absence of pneumoconiosis and one is admitted as a quality-only reading.[8] The chest x-ray evidence submitted in the current claim is summarized in the following table:

[7] Additional chest X-ray interpretations, which are not classified as the Regulations prescribe, are included in the records of hospitalization and treatment.

[8] As part of the Claimant's Department of Labor-sponsored complete pulmonary evaluation, Dr. Ronald Duncan completed a "Roentgenographic Quality Reading" of the November 21, 2002 X-ray on January 20, 2003. (DX 13). Dr. Duncan included, in the comments section of the form, a finding of opacities at the profusion of 2/2. However, because his reading was a quality reading and not a reading for the existence of pneumoconiosis, I redact these comments and consider his reading for quality purposes only.

Exhibit Number	Dates: X-ray/ Reading	Reading Physician	Radiological Qualifications[9]	Film Quality	ILO Classification, Interpretation, or Impression
DX 13	11/21/02 11/21/02	Gaziano	B-reader	1	2/3, q,t; all zones
DX 13	11/21/02 1/20/03	Duncan	B-reader Board certified	2 (light)	Quality-only reading.
DX 17	11/21/02 6/13/03	Wiot	B-reader Board certified	1	No abnormalities consistent with pneumoconiosis.
CX 6	11/21/02 2/4/05	Miller	B-reader Board certified	1	3/2, q,t
DX 15	3/24/03 5/15/03	Wiot	B-reader Board certified	1	No abnormalities consistent with pneumoconiosis.
CX 4	3/24/03 5/19/04	Miller	B-reader Board certified	1	3/2, t,q
EX 4	4/28/04 6/9/04	Wheeler	B-reader Board certified	3 (light)	No abnormalities consistent with pneumoconiosis.
CX 3	4/28/04 2/4/05	Miller	B-reader Board certified	1	3/2, q,t
CX 1	4/30/04 5/19/04	Miller	B-reader Board certified	3 (overexposed)	3/2, t,q
CX 2	4/30/04 5/27/04	Capiello	B-reader Board certified	3 (overexposed)	2/3, q,s; all zones
EX 5	4/30/04 12/2/04	Wheeler	B-reader Board certified	2 (light)	No abnormalities consistent with pneumoconiosis.
EX 5(a)	4/30/04 12/2/04	Scott	B-reader Board certified	2 (light)	No abnormalities consistent with pneumoconiosis.

B. CT Scans

The parties each have submitted an interpretation of a May 13, 2002 CT scan.[10]

A CT scan is a "computed tomography scan or computed aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an X-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths." *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(citing *The Bantam Medical Dictionary*, 96, 437 (Rev. Ed. 1990)).

CT scans are admissible as "other medical evidence" under 20 C.F.R § 781.107(a), which provides for the submission of "[t]he results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate [*inter alia*] the presence or absence of pneumoconiosis[.]" *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-123

[9] A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Greater weight may be accorded to the X-ray interpretation of a physician who is dually qualified as both a B-reader and board certified in radiology. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished).

[10] Additional CT scan interpretations are included in the records of hospitalization and treatment.

(2006)(citing 20 C.F.R. § 718.107(a); *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47, 1-49 (2004)). Each party may submit one interpretation of each CT scan in support of its affirmative case and one reading in rebuttal of each submitted affirmatively by the opposing party. *Webber* at 8-9; *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006).

The Employer submitted Dr. Jerome Wiot's May 15, 2003 interpretation of the May 13, 2002 CT scan. (DX 15). Dr. Wiot found that the CT "confirms there is no evidence of [CWP]." He found changes primarily in the bases of the lungs, but also in the mid zones with interstitial change and ground glass consistent with UIP/IPF. Dr. Wiot also stated that this finding represents a manifestation of pleural disease rather than coal dust exposure. (DX 15).

In rebuttal, the Claimant submitted Dr. Thomas Miller's June 7, 2004 interpretation of the May 13, 2002 CT scan. (CX 7). Dr. Miller reported evidence of a moderately severe, somewhat patchy interstitial lung disease with a predominantly-reticular appearance, greater in the lower lungs than the upper lungs. He found this appearance to be nonspecific "but could be consistent with pneumoconiosis." He also found tiny bullae, mild bronchiectasis, and a small amount of thin, finely nodular pleural thickening. Dr. Miller also found no pulmonary masses or pleural fluid collections but did find some degree of honeycombing in the lower sections. He also noted a small-calcified granuloma. (CX 7).

C. Biopsy Reports

The Regulations allow each party to submit one report of each biopsy in support of its position. 20 C.F.R. § 725.414(a)(2)(i) & (3)(i). A report of a biopsy "shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of the lungs." 20 C.F.R. § 718.106(a).

The Claimant submitted the November 25, 2005 biopsy report of Dr. Joshua Perper.[11] Dr. Perper is board-certified in anatomical, surgical and forensic pathology and is the Chief Medical Examiner of Broward County, Florida. Dr. Perper reviewed five biopsy slides. (DX 62 at 20). Dr. Perper included various pictures of the lung tissue that show it gross macroscopically. (DX 62 at Figures 1-20). He also provided a written description of each photograph. (*See* DX 62 at 21-22). He made the following microscopic findings:

(a) The pleura shows severe fibro-anthracosis with the presence of birefringent silica crystals.
(b) The pulmonary parenchyma shows in several places interstitial and compact anthraco-fibrosis with the presence of birefringent silica crystals.

[11] The Claimant submitted this same report as both a biopsy report and as one of its two allotted medical reports. In preparing this single document, Dr. Perper reviewed pathology slides as well as myriad medical evidence. I admit the exhibit as both a biopsy report and a medical report. However, for the purpose of considering it as a biopsy report, I will only consider Dr. Perper's review of the pathologic slides but not his review of additional medical evidence. *See Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.)(holding that where a single document contains both a pathology review and a consideration of additional medical evidence, it may be considered as a biopsy report only to the extent that it offered "an assessment of claimant's biopsy tissue for the existence of pneumoconiosis.").

(c) Other areas of the lungs show interstitial and compact fibrosis with smaller deposits of anthracotic pigment containing birefringent silica crystals, some of which is consistent with organized pneumonia/bronchiolitis obliterative organizing pneumonia ("BOOP").
(d) In one case of the organizing pneumonia, an enlarged airway space contains a foreign body granuloma with foreign body type of multinucleated giant cells, most likely a reaction to aspirated gastric contents.
(e) Centrilobular emphysema, moderate severity.
(f) Intrapulmonary blood vessels show severe thickening and sclerosis of their walls.

(DX 62 at 20).

From these findings, Dr. Perper made the following four diagnoses:

(1) CWP, severe, primarily interstitial type with solid fibro-anthracotic area in excess of 1.5 cm and consistent with complicated CWP (Progressive Massive Fibrosis).
(2) Centrilobular emphysema, moderate to marked.
(3) Organized pneumonia/BOOP.
(4) Sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension.

(DX 62 at 21).

In rebuttal, the Employer submitted the September 1, 2004 and March 1, 2006 reports of Dr. Stephen Bush, which were redacted to reflect only Dr. Bush's review of pathologic slides and Dr. Perper's report (EX 3(b)). Dr. Bush is board certified in anatomic and clinical pathology with a special competence in medical microbiology. Dr. Bush reviewed the same slides as Dr. Perper. (*see* EX 3(b), 9/1/04 report, at 2)). Based on his slide review, Dr. Bush concluded that the lungs show no evidence of CWP. (EX 3(b), 9/1/04 report, at 3). Rather, he found evidence of severe diffuse fibrotic disease with scattered dust pigment and polarizing particles of silicates, some of which appear to be engulfed by a few foreign body giant cells; however, he found no macules or nodules. (EX 3(b), 9/1/04 report, at 3-4). Dr. Bush further stated that these histologic findings are consistent with the diagnosis of idiopathic pulmonary fibrosis in an individual incidentally exposed to occupational dust. (EX 3(b), 9/1/04 report, at 4). He noted that this diagnosis is consistent with the gross description of the tissue. Additionally, Dr. Bush specifically disagreed with Dr. Perper's conclusions. (EX 3(b), 3/1/06 report at 1). Notably, he stated his belief that Dr. Perper exaggerated the amount of dust pigmentation he found. (EX 3(b), 3/1/06 report at 2). Thus, Dr. Bush again found that there is insufficient evidence to justify a diagnosis of CWP. (EX 3(b), 3/1/06 report, at 3).

The Employer also affirmatively submitted the July 2, 2003 report of Dr. Erika Crouch. (DX 18). Dr. Crouch is board certified in anatomic pathology. She reviewed the same

pathologic slides as Drs. Perper and Bush. (*see* DX 18 at 1).[12] Based on her review, Dr. Couch made the following microscopic findings:

(a) End stage pulmonary fibrosis with honeycombing and non-obstructive changes;
(b) Moderate amounts of short dark brown to yellow-brown particles consistent with coal dust as well as larger plate-like and polarizable particles consistent with silicates;
(c) Very little parenchyma;
(d) No coal dust macules, micronodules, or nodules are identified;
(e) A few small hyalinized granulomas, etiology uncertain;
(f) No areas with the appearance of massive fibrosis or complicated silicosis observed;
(g) Scattered ferrunginous bodies but most contain black cores or sheet silicates and no definitive asbestos bodies are observed.

(DX 18 at 2).

Based on these findings, Dr. Crouch made the following diagnoses:

(1) End stage pulmonary fibrosis with honeycombing;
(2) Rare, small hyalinized granulomas of uncertain significance; and,
(3) Dust deposition.

With respect to her finding of dust deposition, Dr. Crouch stated that, although there is evidence of mixed dust deposition, there is no histologically discernable evidence of CWP. (DX 18 at 2). Moreover, the pattern of fibrosis does not suggest a dust-related etiology. (DX 18 at 2). Thus, Dr. Crouch concluded that her pathologic examination of the biopsy revealed no evidence of CWP, or other dust-related lung disease. (DX 18 at 3).

D. Pulmonary Function Studies

Pulmonary function studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity ("FVC"), forced expiratory volume in one second ("FEV_1"), and maximum voluntary ventilation ("MVV").

The record in this claim contains the results of three PFS tests. Drs. Crisalli and Zaldivar conducted the test both before and after the application of bronchodilators. Dr. Gaziano only conducted the test absent the application of bronchodilators. The results of these tests are summarized in the table below.

[12] Additionally, Dr. Crouch also referred to "miscellaneous medical and occupational records" and later to "accompanying radiographic reports." Reference to this material exceeds the scope of a biopsy report. *See Tapley,* BRB No. 04-0790 BLA. Therefore, these references, and any accompanying conclusions, are redacted.

Physician Date Exhibit #	Age Height	FEV_1	MVV	FVC	Tracings	Comprehension Cooperation	Conforming[13]	Qualifying[14]
Gaziano 11/21/02 DX 13	65 69"	2.51	69	3.35	Yes	Good Good	Yes	No
Crisalli 3/24/03 DX 14	65 69.5"	Pre: 2.61 Post: 2.71	Pre: 82	Pre: 3.51 Post: 3.53	Yes	Effort variable.	Yes	Pre: No Post: No
Zaldivar 4/28/04 EX 1	66 69"	Pre: 2.63 Post: 2.62		Pre: 3.56 Post: 3.49	Yes		Yes	Pre: No Post: No

As indicated above, Drs. Gaziano and Zaldivar reported the Claimant's height as 69 inches while Dr. Crisalli reported it as 69.5 inches. The fact-finder must resolve conflicting heights reported in the various PFS tests of record. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983).[15] Here, I find that the Claimant's height is 69 inches, which represents the height most reported.

[13] A study "conforms" if it complies with the applicable standards found in 20 C.F.R. § 718.103.
[14] A "qualifying" study yields values that are equal to or less than the values set forth in Appendix B of Part 718 of the Regulations.
[15] *But see Toler v. E. Assoc. Coal Co.*, 42 F.3d 3 (4th Cir. 1995)(noting that this is particularly important in cases unlike this one, where resolution of such a conflict would effect whether or not a study qualifies).

None of the PFS tests of record have produced qualifying values. For a miner of the Claimant's height of 69 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.89 for a male 65 years of age and 1.87 for a male 66 years of age. If such an FEV_1 is shown, there must be in addition, either an FVC or MVV value meeting the regulatory requirements, or a ratio equal to or less than 55% when the results of the FEV_1 are divided by the results of the FVC. Here, however, because none of the tests has produced the requisite FEV_1, none is qualifying.

E. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli, which will leave the miner disabled.

The record in this claim contains the results of three blood gas studies. Drs. Gaziano and Zaldivar performed the studies both at rest and after exercise. Dr. Crisalli performed study at rest only. The results of these studies are summarized in the table below.

Date **Exhibit #**	**Physician**	**PCO_2**	**PO_2**	**Qualify**[16]
11/21/02 DX 13	Gaziano	Resting: 41 Exercise: 38	Resting: 65 Exercise: 56	Resting: No Exercise: Yes
3/24/03 DX 14	Crisalli	41	79	No
4/28/04 EX 1	Zaldivar	Resting: 33 Exercise: 37	Resting: 73 Exercise: 47	Resting: No Exercise: Yes

F. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability nevertheless may be found, if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or

[16] A blood gas study "qualifies" if it produces a PO_2 equal to or less than the value listed for the corresponding PCO_2 in Appendix C of Part 718 of the Regulations.

pulmonary condition prevents or prevented the miner from engaging in employment, i.e. performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b).

Dr. Dominic Gaziano is a B-reader and board certified in internal medicine with subspecialties in chest diseases and critical care. He examined the Claimant on November 21, 2002 and issued a report dated December 2, 2002. (DX 13). Additionally, the Claimant has submitted a supplemental report authored by Dr. Gaziano, dated May 5, 2004. (DX 13). In his initial report, Dr. Gaziano noted 35 years of coal mine employment and reported that the Claimant was a lifelong nonsmoker. (DX 13). He stated that the Claimant had the following symptoms: sputum, wheezing, dyspnea, cough, orthopnea, and paroxysmal nocturnal dyspnea. (DX 13). Based on a positive chest X-ray, Dr. Gaziano diagnosed the Claimant with CWP and stated that its etiology was coal mining. (DX 13). He also stated that the Claimant had a severe respiratory/pulmonary impairment and is disabled from his regular coal mine work. (DX 13).

In his supplemental report, Dr. Gaziano indicated that the Claimant has an occupational lung disease that was caused by coal mine employment. (CX 10). His basis for this diagnosis was 35 years of coal mine employment and chest X-ray evidence. Dr. Gaziano categorized the Claimant's pulmonary impairment as "severe." He stated that the severe impairment was due to CWP. (CX 10). He further stated that the Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. (CX 10). Dr. Gaziano based this conclusion on the Claimant's low PO_2 level on exercise from the November 21, 2002 blood gas study.

The Claimant has offered the April 30, 2004 medical report of Dr. Sathishchandra Rao. (CX 12).[17] Dr. Rao is board certified in internal medicine. (CX 17). Dr. Rao treated the Claimant regularly for his breathing problems. (*See* TR 30). Dr. Rao's treatment of the Claimant is documented by the records admitted as CX 12 and DX 48.[18] Dr. Rao concluded that the Claimant has an occupational lung disease that was caused by his coal mine employment. He based this conclusion on the Claimant's 35 years of coal mine employment, chest X-ray evidence, and biopsy evidence. He found the Claimant to be totally disabled and stated that the Claimant's impairment is "totally related" to pneumoconiosis. Accordingly, he also found the Claimant to be unable to perform the work of a coal miner or to perform comparable work in a dust-free environment. Dr. Rao based this conclusion on the Claimant's shortness of breath and his oxygen treatment. (CX 12 at 1).

The Claimant also submitted the consultative medical report of Dr. Joshua Perper, whose qualifications are detailed above. (DX 62). In preparation for his report, Dr. Perper reviewed correspondence from the Occupational Pneumoconiosis Board and West Virginia Workman's Compensation Fund, various hospital and treatment records, the medical reports of Drs. Zaldivar, Gaziano, and Rao, pathology reports of Drs. Crouch and Bush, objective CT scan, chest X-ray,

[17] Throughout the course of this litigation, Dr. Rao also has been referred to as "Dr. Sathishchandra" and "Dr. Satish." Based on his resume, I refer to him as "Dr. Rao."

[18] Although I admit Dr. Rao's treatment records as such pursuant to § 725.414(a)(4), his report, which was included in CX 12, is admitted as a medical report pursuant to § 725.414(a)(2)(i) because it was prepared for the purposes of litigation.

blood gas, and PFS test evidence, the lung biopsy report, and the biopsy slides. (DX 62 at 1-2).[19] Dr. Perper noted 35 years of coal mine employment and that the Claimant was a lifelong non-smoker. (DX 62 at 2-3). Based on his review, Dr. Perper arrived at the following conclusions:

(1) The Claimant has evidence of a substantial and significant severe interstitial type of CWP with compact lesions up to 1.5 cm, compatible with complicated CWP.
(2) The Claimant's CWP was causally associated with significant centrilobular emphysema.
(3) The Claimant's CWP is a result of occupational exposure to coal dust.
(4) The Claimant's severe CWP was a substantial cause of his pulmonary impairment and disability. (DX 62 at 32).

Dr. Perper based his finding of CWP on the Claimant's coal mine employment (including type of work performed and dust exposure), chest X-ray evidence, and pathology evidence. (DX 62 at 23). With respect to the pathology evidence, Dr. Perper specifically disagreed with Drs. Bush and Crouch, who found no CWP, because of his findings of massive lesions of compact fibro-anthracosis. (DX 62 at 23-24).

Dr. Perper further explained that he diagnosed severe CWP consistent with complicated pneumoconiosis, or progressive massive fibrosis ("PMF"). (DX 62 at 24). He based this conclusion on findings of interstitial fibrosis with compact fibro-anthracotic exceeding 1.5 cm. (DX 62 at 23). In support, he referenced a wealth of literature that states that a lesion over 1.0 cm is sufficient to qualify for a nodule of complicated pneumoconiosis and relates such a finding to a radiographically observed nodule of greater than 1.0 cm. (DX 62 at 24).

Additionally, Dr. Perper stated that the Claimant exhibits an interstitial fibrosis pattern of CWP. (DX 62 at 26). In support of this assertion, he referenced various studies that describe the existence of such a condition. He then cited his own biopsy review, which revealed severe pulmonary interstitial fibrosis with the presence of anthracotic pigment and birefringent silica crystals consistent with a pattern of the interstitial type of CWP. (DX 62 at 27-28).

With respect to emphysema, Dr. Perper stated generally that pulmonary emphysema may reasonably be attributed to either smoking or coal dust exposure. (DX 62 at 30). He referenced a bevy of medical literature to that effect in support.

With respect to disability causation, Dr. Perper cited five bases for his conclusion that CWP was a substantial cause of the Claimant's pulmonary impairment and disability:

(1) Symptomatic inability to perform because of shortness of breath, cough, and other respiratory symptoms;

[19] Dr. Perper reviewed various pieces of objective medical evidence not admitted into the record. Medical reports must be based on admissible evidence. *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47, 1-66 (2004); 20 C.F.R. § 725.414(a)(2)(i), (a)(3)(i). Therefore, Dr. Perper's references to any evidence not admitted, and any derivative conclusions, are redacted.

(2) Worsening of Claimant's objective pulmonary clinical and radiological findings;
(3) Documented presence of substantial and significant CWP;
(4) Presence of causally associated centrilobular emphysema;
(5) Organized pneumonia also was a contributory cause of death (sic).[20]

(DX 62 at 31).

The Employer submitted the July 21, 2003 medical report of Dr. Robert J. Crisalli. (DX 46). Dr. Crisalli is board certified in internal medicine with a subspecialty in pulmonary diseases. He noted that the Claimant had 26 years of underground coal mine employment, 7-8 years of strip mine employment, and is a lifelong nonsmoker. (DX 46 at 7). He examined the Claimant on March 24, 2003 and made the following diagnoses:

(1) Idiopathic pulmonary fibrosis;
(2) Obstructive sleep apnea;
(3) No evidence of CWP;
(4) Coronary artery disease, with a history of coronary artery bypass grafting surgery;
(5) Hypertension;
(6) Non-insulin dependent diabetes mellitus; and
(7) Obesity. (DX 46 at 1).

Thereafter, he reviewed Dr. Wiot's May 13, 2002 CT scan, the Claimant's claim for benefits and employment history, Dr. Gaziano's November 21, 2002 Department of Labor examination report, the Claimant's answers to interrogatories, dated February 20, 2003, and Dr. Crouch's biopsy report. (DX 46 at 3-4).[21] After reviewing the additional information, in conjunction with his own examination findings, Dr. Crisalli concluded that there is not sufficient evidence to justify a diagnosis of CWP or any chronic dust disease of the lung attributable to coal mine employment. (DX 46 at 4). Instead, he diagnosed idiopathic pulmonary fibrosis. (DX 46 at 4). He based this diagnosis on the fact that this is a disease of the general populations and the absence of pathologic changes of CWP in this case. (DX 46 at 4). Dr. Crisalli also noted, generally, that there is no association of idiopathic pulmonary fibrosis with CWP or coal dust exposure. (DX 46 at 4). Regarding disability, Dr. Crisalli found that the Claimant has a "severe respiratory impairment." (DX 46 at 4). However, Dr. Crisalli stated that the Claimant's impairment is due to his idiopathic pulmonary fibrosis and has nothing to do with coal dust exposure. (DX 46 at 4). Finally, Dr. Crisalli stated that his opinion regarding the degree and cause of the Claimant's respiratory impairment and related disability would not change even if the Claimant were deemed to have CWP because the entire clinical picture shows evidence only of idiopathic pulmonary fibrosis and not CWP. (DX 46 at 5).

[20] In addition to his obviously erroneous reference to the Claimant's death, Dr. Perper also referred to autopsies at several points throughout his report. I attribute these mistakes to errors in writing and do not find any substantive significance in them.

[21] Dr. Crisalli also made reference to an X-ray interpretation by Dr. Smith. Because this interpretation has not been admitted in this claim, reference to it and any derivative conclusions are redacted.

Dr. Crisalli was deposed on November 14, 2005 and December 18, 2006. The Employer has submitted the transcripts of those depositions, which are admissible pursuant to 20 C.F.R. § 725.414(c). (EX 7).[22] At the November 15, 2005 deposition, Dr. Crisalli classified the exertional level of the Claimant's last coal mine position as light work with activities of medium to very sparse periods of heavy labor. (EX 7(a) at 9). Dr. Crisalli stated that, based on his examination, he found that the Claimant exhibited an interstitial process, such as fibrosis or interstitial pneumonitis. (EX 7(a) at 11). Dr. Crisalli then described the chest X-ray evidence he reviewed, including multiple readings of the November 21, 2002, March 24, 2003, and August 28, 2004 X-rays. (EX 7(a) at 11-18).[23] Dr. Crisalli also noted his review of Dr. Crouch's biopsy report as well as the original biopsy report. (EX 7(a) at 23-29). He also reviewed the interpretations of Drs. Churg and Aubry at the Mayo Clinic. (EX 7(a) at 29). Dr. Crisalli criticized the interpretations of the biopsy that were positive for CWP because they did not indicate a finding of coal dust macules. (*see* EX 7(a) at 28 & 31). Moreover, he believed that Drs. Churg and Aubry assumed CWP because of the Claimant's coal mine employment but did not support this finding with objective evidence. (EX 7(a) at 32-33). Dr. Crisalli then opined, based on the PFS and blood gas evidence of record, that the Claimant does not have the pulmonary capacity to return to his last coal mine job. (EX 7(a) at 36-37). He attributed the Claimant's condition to idiopathic pulmonary fibrosis. (EX 7(a) at 37). Moreover, he did not believe that coal dust exposure contributed to the Claimant's impairment. (EX 7(a) at 37).

At the December 28, 2006 deposition, Dr. Crisalli testified that he reviewed Dr. Perper's report subsequent to his prior deposition. (EX 7(b) at 6). Dr. Crisalli stated that he specifically disagreed with Dr. Perper's findings of CWP and progressive massive fibrosis. (EX 7(b) at 7). With respect to progressive massive fibrosis, Dr. Crisalli stated that Dr. Perper's own description contradicted his finding because he did not describe lesions of progressive massive fibrosis. (EX 7(b) at 7). Rather, Dr. Crisalli opined that what Dr. Perper described is a large scar of pulmonary fibrosis, which has nothing to do with pneumoconiosis. (EX 7(b) at 8). He also noted that there is no other description of progressive massive fibrosis anywhere else in the Claimant's medical record. (EX 7(b) at 9). Additionally, Dr. Crisalli disagreed with Dr. Perper's diagnosis of simple CWP because, he opined, what Dr. Perper described was evidence of idiopathic pulmonary fibrosis, not CWP. (EX 7(b) at 13-14). Specifically, Dr. Crisalli criticized Dr. Perper for finding the presence of coal dust in the Claimant's lung and "mak[ing] a leap" to connect that coal dust to the Claimant's condition, when no such medically sound link exists. (EX 7(b) at 14). Moreover, he criticized Dr. Perper for diagnosing pneumoconiosis without citing any coal dust macules. (EX 7(b) at 18). Dr. Crisalli stated that the absence of coal macules rules out the possibility that coal dust exposure contributed to the Claimant's impairment. (EX 7(b) at 18). Dr. Crisalli also stated that Dr. Perper's comment concerning the potential causal link between coal dust exposure and COPD is not applicable to this case because the Claimant does not have COPD, as demonstrated by pulmonary function. (EX 7(b) at 18). Dr. Crisalli concluded that Dr. Perper's report did not change any of his opinions about this case. (EX 7(b) at 20).

[22] Although the Employer did not distinguish between these exhibits at the hearing, I designate the transcript of the November 15, 2005 deposition as EX 7(a) and the transcript of the December 18, 2006 deposition EX 7(b).

[23] Dr. Crisalli then described his review of interpretations of a June 13, 2002 CT scan by Drs. Wiot and Amhed. Because these interpretations have not been admitted into the record, reference to them, and any derivative conclusions, are redacted.

The Employer also submitted the report of Dr. George L. Zaldivar, dated July 6, 2004. (EX 1). Dr. Zaldivar is a B-reader and board certified in internal medicine with subspecialties in pulmonary diseases and sleep disorders. He examined the Claimant on April 28, 2004. (EX 1 at 1). He had previously examined the Claimant on April 10, 1996, in connection with the prior claim. In preparation for his report, Dr. Zaldivar reviewed the Department of Labor questionnaire, interrogatories completed by the Claimant, the medical reports of Dr. Gaziano, Rao, and Crisalli, the biopsy report of Dr. Crouch and the original biopsy report, various records of hospitalization and treatment, blood gas and PFS test evidence, CT scan evidence, and chest X-ray evidence. (EX 1 at 2-6).[24] Based on his examination and review of the evidence, Dr. Zaldivar concluded that:

(1) There is no evidence in this case to justify a diagnosis of CWP or any dust disease of the lungs;
(2) There is a severe pulmonary impairment present. From a pulmonary standpoint, the Claimant has a very severe degree of impairment. He is incapable of performing any work above the sedentary level;
(3) The Claimant's pulmonary impairment is the result of pulmonary fibrosis, unrelated to his occupation as a coal miner. The degree of impairment is the result of fibrosis, which results in hypoxemia with any degree of activity;
(4) Even if coal macules were found histologically, such would constitute an incidental finding, unrelated to the Claimant's main problem, which is the pulmonary fibrosis itself. Therefore, even if coal macules were found by histologic evaluation, Dr. Zaldivar's opinion regarding the cause of the pulmonary impairment, as well as degree of impairment, would remain the same. (EX 1 at 8).

With respect to the absence of pneumoconiosis, Dr. Zaldivar credited Dr. Crouch's negative biopsy report and criticized Dr. Mangano's positive report for failing to cite any macules. (EX 1 at 7). He also noted that most of the B-readers found changes present in the mid and lower zones, which is typical of a process other than CWP. (EX 1 at 7). Dr. Zaldivar also commented that most of the B-readers found characteristics typical of pulmonary fibrosis and unrelated to CWP. (EX 1 at 7).

The Employer also submitted Dr. Zaldivar's March 6, 2006 supplemental report, which accounts for his review of Dr. Perper's report. (EX 1(a). After reviewing Dr. Perper's report, Dr. Zaldivar stated that his opinion remained the same as what he expressed in his 2004 report. (EX 1(a) at 5). Dr. Zaldivar first took issue with Dr. Perper's finding of pneumoconiosis based on his own review of the pathology slides and chest X-ray evidence. Specifically, he noted that other pathologists found the same slides to be negative for pneumoconiosis and that the pathology evidence, as a general rule, trumps the X-ray evidence. (EX 1(a) at 2). He also took

[24] Dr. Zaldivar reviewed numerous chest X-ray and CT scan interpretations that have not been admitted into evidence. Reference to these exhibits, and any derivative conclusions, are redacted. These exhibits include: Dr. Meyer's reading of a May 13, 2002 CT scan, Dr. Spitz's reading of a May 13, 2002 CT scan, Dr. Wiot's reading of an October 9, 2002 chest X-ray, Dr. Meyer's readings of chest X-rays dated September 6, 2002 and September 4, 2002, Dr. Amhed's reading of a May 13, 2002 CT scan, Dr. Pathak's reading of a May 13, 2002 CT scan, Dr. Miller's reading of an October 9, 2002 chest X-ray, and Dr. Smith's reading of an October 9, 2002 chest X-ray.

issue with Dr. Perper's finding of complicated pneumoconiosis (progressive massive fibrosis), criticizing the clinical studies he cited for support. (EX 1(a) at 2-3). Dr. Zaldivar also noted that no other pathologist found complicated pneumoconiosis in this case. (EX 1(a) at 3). Dr. Zaldivar then took issue with Dr. Perper's finding that the Claimant had centrilobular emphysema caused by CWP, noting that there was no evidence that the Claimant actually had centrilobular emphysema. Finally, Dr. Zaldivar criticized Dr. Perper's conclusion that CWP caused his pulmonary emphysema, noting that no medical causal link exists between the two. (EX 1(a) at 4).

Dr. Zaldivar was deposed on November 15, 2005 and January 2, 2007. The Employer has submitted the transcripts of those depositions, which are admissible pursuant to 20 C.F.R. § 725.414(c). (EX 6).[25] At his first deposition, Dr. Zaldivar stated that he understood the Claimant's work history to include 35 years of coal mine employment, which included four or five years of truck driving at a strip mine at the end of his career. (EX 6(a) at 7). Dr. Zaldivar described, in great detail, the medical evidence he reviewed. He specifically criticized Dr. Miller's reading of the April 28, 2004 X-ray as inconsistent with contemporaneous pathology. (EX 6(a) at 15). He also criticized Dr. Mangano's biopsy report for his finding of interstitial pulmonary fibrosis associated with coal dust exposure. (EX 6(a) at 27). According to Dr. Zaldivar, there is no medical link between interstitial fibrosis and coal dust inhalation. (EX 6(a) at 27). Dr. Zaldivar also criticized the Mayo Clinic records for similar reasons. (EX 6(a) at 28-29). Additionally, Dr. Zaldivar stated that the PFS evidence he reviewed revealed no obstructive impairment, which bolstered his finding of pulmonary fibrosis. (EX 6(a) at 31-35). He also found the blood gas evidence to be reflective of pulmonary fibrosis. (EX 6(a) at 35-36). Dr. Zaldivar also reiterated his conclusion that the Claimant does not have the pulmonary capacity to return to his last coal mine job. (EX 6(a) at 40). However, he again stated that the cause of the Claimant's impairment is pulmonary fibrosis, not coal dust exposure. (EX 6(a) at 40). Finally, he reiterated his conclusion that the Claimant does not have any type of pneumoconiosis. (EX 6(a) at 40).

At his second deposition, Dr. Zaldivar commented that, after reading Dr. Perper's report, his opinions concerning the Claimant's condition did not change. (EX 6(b) at 4). Dr. Zaldivar specifically disagreed with Dr. Perper's findings of simple CWP, complicated pneumoconiosis, and that the Claimant's pulmonary fibrosis was due to coal dust inhalation. (EX 6(b) at 4-9). Dr. Zaldivar also criticized those physicians who listed a diagnosis of pneumoconiosis during the Claimant's treatment, stating that these diagnoses were not based on an independent evaluation of the Claimant to determine the presence or absence of the disease. (EX 6(b) at 10-11). Dr. Zaldivar again commented that the Claimant's pattern of impairment favored a finding of pulmonary fibrosis rather than CWP. (EX 6(b) at 11). Finally, Dr. Zaldivar again reiterated his conclusions that the Claimant does not have pneumoconiosis, does have a totally disabling pulmonary impairment, but that his total disability is due to pulmonary fibrosis. (EX 6(b) at 21-23).

[25] Although the Employer has not distinguished between the two depositions, I designate the transcript of the November 15, 2005 deposition EX 6(a) and the transcript of the January 2, 2007 deposition EX 6(b).

G. Hospitalization and Treatment Records

Notwithstanding the § 725.414 evidentiary limitations, any record of a miner's hospitalization or medical treatment for a respiratory or pulmonary or related disease may be received into evidence. 20 C.F.R. § 725.414(a)(4).

The Claimant submitted records from Thoracic and Cardiovascular Associates. (DX 47). These records document the Claimant's June 27, 1992 coronary artery bypass graft and his September 5, 2002 biopsy. (DX 47). Regarding the latter, the records contain documentation of the August 8, 2002 examination, at which Dr. Hasan ordered the biopsy. In the report of that examination, Dr. Hasan included a diagnosis of interstitial fibrosis with restrictive lung disease. An examination in preparation of the biopsy, dated September 5, 2002, included a chest X-ray, which revealed changes most consistent with pulmonary fibrosis and a diagnosis of CWP. It also reported a CT scan "done in May" that showed non-specific interstitial fibrosis. The lung biopsy was read by Dr. Mangano in a report dated September 6, 2002. Dr. Mangano listed the following diagnoses: CWP, including fibrosis and coal dust deposition, a minor component of bronchiolitis obliterions, and organizing pneumonia. The records also including a consultative reading of the biopsy conducted at Mayo Medical Laboratories, dated September 23, 2002. This report was signed by Dr. Aubry with consultation from Dr. Churg. This reading lists the final diagnosis as interstitial pulmonary fibrosis associated with coal dust exposure.

Finally, these records also contain three chest X-ray interpretations. The first, dated September 4, 2002 and read by Dr. Smith, listed an impression of chronic organizing interstitial changes in the lung bases, most consistent with pulmonary fibrosis. The second, dated September 6, 2002 and read by Dr. Reifsteck, listed an impression including minimal right basilar pneumothorax and bilateral basilar atelectasis with chronic interstitial changes. The third, dated October 10, 2002 and read by Dr. Dwyer, listed an impression of diffuse changes of pulmonary fibrosis.

The Claimant also submitted another set of hospital and treatment records, which include records from Dr. Rao, Charleston Heart Specialists, and Thoracic and Cardiovascular Associates. (DX 48). These records span June 27, 1992 to April 3, 2003. These records contain the results of several objective tests, including:

- A PFS test, dated June 6, 2001, that produced non-qualifying results;
- A chest X-ray, dated May 23, 1997 and read by Dr, Al-Asadi, which showed chronic interstitial changes;
- A chest X-ray, dated November 5, 1996 and read by Dr. Subramaniam, which showed chronic lung changes;
- A chest X-ray, dated April 12, 1995 and read by Dr. Kondroski, which showed chronic fibrotic changes at the lung bases and no acute disease in the chest;

These records also included documentation of two periods of hospitalization. The first spanned June 21, 1992-July 3, 1992 and involved a cardiac catheterization. It included a post-

operative finding of "very tiny lt. apical pneumoconiosis." The second spanned September 28, 1993-October 1, 1993 and involved a left heart catheterization and coronary angiograms.

The records also contained the report of a May 6, 2002 pulmonary examination, conducted by Dr. Al-Asadi. In preparation for his report, Dr. Al-Asadi reviewed a June 2000 chest X-ray, which showed increased interstitial markings in both lung bases and a mild restrictive pattern with severe reduction in diffusion capacity. Based on his examination, Dr. Al-Asadi found symptoms consistent with pulmonary fibrosis, which could be idiopathic. Subsequently, he reviewed a high resolution CT scan, in a report dated May 23, 2002, which showed a bilateral middle lobe and lower fibrosis. Dr. Al-Asadi also commented that the CT findings were most probably consistent with pulmonary fibrosis and the possibility of obstructive sleep apnea. He recommended a lung biopsy to determine the nature of the lung disease.

The records also contain Dr. Skeens' reading of a CT of the thorax, dated May 13, 2002, in which he found non-specific interstitial fibrosis primarily involving the mid and lower lung zones.

Also included is the letter from Dr. Basu, a cardiologist, to Dr. Rao regarding the general condition of the Claimant. Dr. Basu noted that he "suspected" that the Claimant's shortness of breath is due to pneumoconiosis but also noted that the Claimant had not had any pulmonary evaluation in some time. Dr. Basu stated that he would refer to the Claimant to a pulmonologist (i.e. Dr. Al-Asadi).

The Claimant submitted additional medical treatment records of Dr. Al-Asadi, which span July 30, 2002-January 27, 2005. (CX 11). On July 30, 2002, Dr. Al-Asadi ordered a lung biopsy. On September 11, 2002, Dr. Al-Asadi reported the readings of a chest X-ray, which showed bilateral infiltrates consistent with pulmonary fibrosis. He also reported that preliminary lung biopsy results came back consistent with CWP. From September 26, 2002-January 27, 2005, Dr. Al-Asadi consistently reported the Claimant as having a history of CWP, pulmonary fibrosis, COPD, and UIP.

The Claimant also submitted Dr. Rao's medical records. (CX 12). These records included several pieces of handwritten notes and an outpatient progress note, signed by Dr. Kukkillaya on September 11, 2003. That progress note included diagnoses of COPD and pneumoconiosis.

III. Witness Testimony

The Claimant testified at the February 15, 2007 hearing. He stated that he did not work anywhere else after ceasing work with the Employer. (TR 25-26). His last coal mine job for the Employer was driving a truck on the strip. (TR 26). That job primarily involved hauling and dumping rock, but also involved lifting cables weighing up to fifty pounds. (TR 26). The Claimant also testified that he worked seven years on the strip, but the rest of his coal mine employment was spent underground. (TR 27). While he worked underground, the Claimant ran the continuous miner. (TR 27). This work involved lifting as much as 100 pounds. (TR 28).

The Claimant also testified that he had experienced breathing problems since leaving coal mining in 1991. (TR 28). His breathing problems have continued to the present time. (TR 29). He is currently on oxygen for his breathing. (TR 30). The Claimant stated that he has trouble breathing when he tries to lift 20 pounds. (TR 34).

Finally, the Claimant testified that he had never smoked cigarettes nor used any other tobacco products. (TR 36).

IV. Prior Claims Evidence

Because there exists a material change in the Claimant's condition since the most recent prior denial of his claim, the evidence from his first two claims is considered for the current living miner's claim. 20 C.F.R. § 725.309(d)(1).[26]

The Claimant's first claim for benefits included the following medical evidence:

• A June 16, 1995 reading of the June 16, 1995 chest X-ray, read by Dr. Ranavaya, with a profusion of 1/0, p,q.
• A July 16, 1995 reading of the June 16, 1995 chest X-ray, read by Dr. Franke, with a profusion of 1/1, p,s.
• A March 11, 1996 reading of a June 16, 1995 chest X-ray, read by Dr. Wiot, who found no abnormalities consistent with pneumoconiosis.
• A March 19, 1996 reading of the June 16, 1995 X-ray, read by Dr. Spitz, who found no abnormalities consistent with pneumoconiosis.
• A June 16, 1995 PFS test, conducted by Dr. Ranavaya, which produced non-qualifying results.
• A blood gas study, conducted on June 16, 1995 by Dr. Ranavaya, which produced non-qualifying results.
• A June 16, 1995 medical report issued by Dr. Ranavaya. It included the following diagnoses:
    (1) Pneumoconiosis;
    (2) Coronary artery disease;
    (3) Hypertension:
    (4) A minimal degree of impairment.
• An April 10, 1996 blood gas study, conducted by Dr. Zaldivar, which produced non-qualifying results.
• An April 10, 1996 PFS test, conducted by Dr. Zaldivar, which produced non-qualifying results.
• An April 26, 1996 reading of the April 10, 1996 chest X-ray, read by Dr. Zaldivar, who found no abnormalities consistent with pneumoconiosis.
• A May 1, 1996 medical report issued by Dr. Zaldivar, who made the following conclusions:
    (1) No evidence of CWP or any damage to the lungs caused by coal dust exposure.

[26] For a discussion of why a material change exists, see *infra* Part B.

(2) The Claimant had a pulmonary impairment, which was caused by pulmonary fibrosis. His impairment was not related to his coal mine employment.
(3) The Claimant's last coal mine job was within his pulmonary capacity;
(4) Even if the Claimant were found to have CWP, Dr. Zaldivar's opinion regarding cause of pulmonary impairment remains the same

FINDINGS OF FACT AND CONCLUSIONS OF LAW[27]

A. Entitlement to Benefits

This claim must be adjudicated under the Regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the Claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and, (4) the pneumoconiosis contributes to the total disability. 20 C.F.R. § 725.202(d)(2) (citing 20 C.F.R. § 718.202-204). Failure to establish any one of these elements precludes entitlement to benefits. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3d Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501(2003), *citing Director, OWCP v. Greenwhich Collieries [Ondecko]*, 512 U.S. 267, 281 (1994).

B. Subsequent Claim Analysis

Because the living miner's claim is the miner's second claim for benefits, and he filed it after January 19, 2001, the Claimant must demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d)(2001); *accord Dempsey v. Sewell Coal Co.* 23 B.L.R. 1-47 (2004). The "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

Although the new regulations dispense with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), and adopted by the Fourth Circuit in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*), *rev'g* 57 F.3d 402 (4th Cir. 1995).

[27] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment is determinative of circuit court jurisdiction. Here, because the miner's last coal mine job occurred in West Virginia, Fourth Circuit law controls.

To assess whether a material change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven at least one of the elements of entitlement previously adjudicated against him in the prior denial. *Rutter*, 86 F.3d 1358. If the claimant establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in a prior claim to determine whether it "differs qualitatively from the new evidence. *Rutter*, 86 F.3d at 1363 n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits.

The Claimant's first application for benefits was denied because he failed to establish any element of entitlement.[28] Therefore, the Claimant must show the existence of one such element by way of newly submitted medical evidence in order to show that a material change in conditions has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

In this case, the Claimant has established one element previously adjudicated against him because the new evidence establishes the existence of a total disability.

Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevented him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony.

In this case, the new evidence establishes the existence of a total disability because all of the physicians who offered opinions in connection with the current claim found that the Claimant has a totally disabling pulmonary impairment.[29] These opinions are buttressed by the fact that both blood gas tests administered after exercise produced qualifying values. I find that this

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[28] Here, the relevant elements of entitlement to consider in this case merit a brief discussion. As explained above, in the Claimant's initial claim, the District Director found that the Claimant established the existence of pneumoconiosis and that the his pneumoconiosis arose out of coal mine employment, but did not establish the existence of a total disability or that his total disability was due to pneumoconiosis. After his request for a hearing, the case was dismissed by an Administrative Law Judge because the Claimant did not appear at the hearing and failed to respond to an Order to Show Cause. The Regulations state that "[t]he dismissal of a claim shall have the same effect as a decision and order disposing of the claim on its merits." 20 C.F.R. § 725.466. Thus, because the Administrative Law Judge's dismissal of the claim is treated as a decision on the merits, it is also treated as though all elements of entitlement were adjudicated against the Claimant. Therefore, in the current claim, the Claimant may prove one element of entitlement previously adjudicated against him by establishing any such element.

I note, however, that because the Claimant has established the existence of a total disability, the basis for the "one element" analysis is largely academic. Specifically, if the basis for conducting this analysis was the District Director's findings, which included two findings in the Claimant's favor but not the existence of a total disability, or the Administrative Law Judge's dismissal, which resulted in all elements adjudicated against the Claimant, the Claimant can establish the requisite "one element" by establishing total disability, which he has established.

[29] I note that Dr. Perper never explicitly quantified the degree of the Claimant's disability as "total." However, he referred to a disability and, taking his report as a whole, I find that it supports the existence of a total disability.

support for the existence of a total disability outweighs the countervailing evidence- namely the non-qualifying values of all PFS tests and at-rest blood gas tests, because of the unanimity of the medical opinion evidence, and its support from objective evidence of record.

Therefore, because the Claimant has established the existence of a total disability, he has established one element adjudicated against him in the prior claim, as required by § 725.309(d). Therefore, the entire record must be considered in the living miner's claim to determine entitlement to benefits.

C. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b); 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[30]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Thus, "pneumoconiosis," as defined by the Act, has a much broader legal meaning than does the medical definition.[31]

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted

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[30] The Regulations specifically state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[31] Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis, if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, COPD also may be encompassed within the legal definition of pneumoconiosis, if it arises out of coal mine employment. *Warth v. S. Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995); *see also* 20 C.F.R. § 718.201(a)(2).

and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or, (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the Administrative Law Judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an Administrative Law Judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the Court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997).

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). Where two or more interpretations of the same X-ray are in conflict, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays. 20 C.F.R. § 718.202(a)(1); *Dixon v. N. Camp Coal Co.*, 8 B.L.R. 1-344 (1985).[32] Additionally, an Administrative Law Judge may consider the numerical superiority of the readings of that X-ray. *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990); *cf. Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990)(noting that the Administrative Law Judge is not required to do so). Finally, it is proper for an Administrative Law Judge to accord greater weight to the more recent X-ray evidence of record. *See Sanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983).

In this case, although a close call, the properly classified chest X-ray evidence supports the existence of pneumoconiosis.[33] Initially, based on recency, I first note that I accord greater weight to the readings submitted in the current claim over those submitted in the prior claim, particularly given that the time difference between the two exceeds five years. Next, I find the November 21, 2002 X-ray to be positive. To that end, two dually qualified physicians have interpreted the X-ray, one reading it positive and one reading it negative for pneumoconiosis. The tie is broken by the positive reading of Dr. Gaziano, a B-reader. The three remaining X-rays, those taken on March 24, 2003, April 28, 2004, and April 30, 2004 respectively, are all in equipoise because each has been read equally positive and negative by dually qualified physicians. Therefore, the current claim contains one positive chest X-ray, zero negative chest X-rays, and three in equipoise. As a result, I find that the chest X-ray evidence supports the existence of pneumoconiosis.

I find that the CT scan evidence of record does not support the existence of pneumoconiosis. As described above, Drs. Wiot and Miller each read the May 13, 2002 CT

[32] As noted above, greater weight may be accorded to the X-ray interpretation of a physician who is dually qualified as both a B-reader and board certified in radiology. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished).

[33] For the purpose of determining the existence of pneumoconiosis, I credit the properly classified readings submitted by the parties over the X-ray evidence contained in the hospitalization and treatment records, as those readings were not classified as prescribed by the Regulations.

scan. Dr. Wiot found no evidence of CWP while Dr. Miller stated that its appearance "could be consistent with pneumoconiosis." Between these two, I credit the opinion of Dr. Wiot, as Dr. Miller's conclusion is equivocal. *See Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). Also, as described above, the CT scan evidence contained in the records of hospitalization and treatment does not include any finding of pneumoconiosis.

I find that the biopsy evidence supports the existence of pneumoconiosis. Initially, I credit the biopsy reports of Drs. Mangano, Bush, and Perper over those of Drs. Crouch and Aubry because the reports of the first three doctors all include gross descriptions, as required by § 718.106. To that end, Dr. Mangano included a section of his report devoted to the "gross description," Dr. Bush referred to the details of the "gross findings" as part of his analysis, and Dr. Perper included the photographs of the samples, along with descriptions. Conversely, the reports of Drs. Crouch and Aubry do not include any such gross descriptions. Between the three credited biopsy reports, Drs. Mangano and Perper both found CWP while Dr. Bush found no evidence of the disease. Therefore, based on the numerical superiority of the credited biopsy reports, I find that the biopsy evidence, as a whole, supports the existence of pneumoconiosis.

I find that the medical report evidence of record supports the existence of pneumoconiosis. To be credited, a medical report must be both well-documented and well-reasoned. A "documented" report sets forth the clinical findings, observations, and facts on which the doctor has based the diagnosis. *Fields v. Director, OWCP*, 10 B.L.R. 1-19 (1987). A report is "reasoned" if the documentation supports the doctor's assessment of the miner's health. *Id*. Upon finding a medical report to be unreasoned, an Administrative Law Judge may reject it entirely or accord it diminished weight in crediting its conclusions. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989). Medical reports may be rejected or accorded diminished weight for a variety of other reasons. Additionally, one medical opinion may be credited over another if it is based upon more extensive medical information. *See Church v. E. Assoc. Coal Corp.*, 20 B.L.R. 1-8 (1996).

In this case, as an initial matter, I accord the medical opinions submitted in the current claim greater weight than those submitted in the prior claim, due to their recency.[34] In this regard, I particularly note the substantial amount of time that passed between the development of the evidence in the respective claims.

With respect to the medical report evidence submitted in the current claim, I accord the opinion of Dr. Gaziano comparatively less weight than the other four opinions because it is based on less extensive medical evidence. Specifically, Dr. Gaziano based his report solely on the medical evidence obtained from the November 21, 2002 examination. Conversely, Drs. Perper, Crisalli, and Zaldivar all based their opinions on reviews of substantially more extensive medical data. Dr. Rao based his opinion on regular treatment of the Claimant. Therefore, by comparison, Dr. Gaziano's opinion is predicated upon comparatively less extensive medical information; thus, I accord it diminished weight when compared with the other opinions of record.

[34] *See Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984)(holding that more recent medical opinion evidence may be accorded weight over earlier medical opinion evidence).

I also accord Dr. Zaldivar's opinion diminished weight because it contains three flaws in reasoning as to the issue of the existence of pneumoconiosis. To that end, Dr. Zaldivar spent much of his opinion supporting his finding of pulmonary fibrosis. This point is related, yet distinct from the relevant inquiry of whether the Claimant has pneumoconiosis. In isolating Dr. Zaldivar's treatment of this inquiry from his finding of pulmonary fibrosis, three deficiencies in reasoning become apparent. First, Dr. Zaldivar supported his criticism of Dr. Perper's pathology review, which was positive for pneumoconiosis, by stating that other pathologists found the same slides to be negative for pneumoconiosis. (EX 1(a) at 2). However, Dr. Mangano found the same slides to be positive for pneumoconiosis, thus tempering the support offered by Dr. Zaldivar's factual premise. Second, Dr. Zaldivar supported his criticism of Dr. Miller's interpretation of the April 28, 2004 X-ray because it was inconsistent with contemporaneous negative pathology. (EX 6(a) at 15). However, again, the record contains pathology that is positive for the existence of pneumoconiosis. Therefore, Dr. Zaldivar's attempts to discredit countervailing evidence are again muffled by the evidence the record contains. Finally, Dr. Zaldivar criticized the treating physicians who found the existence of pneumoconiosis by stating that their assessments were not based on independent evaluations of the Claimant. (EX 6(b) at 10-11). However, Dr. Zaldivar did not provide, nor does the record contain, any evidence to support this assertion. Instead, the treating physicians who made these diagnoses did so within the context of providing regular treatment to the Claimant. Therefore, this criticism of countervailing evidence also carries little weight. Thus, three of Dr. Zaldivar's criticisms of evidence support the existence of pneumoconiosis contain flawed reasoning. Therefore, because he relies on these criticisms to bolster his own conclusion that the Claimant did not have pneumoconiosis, that conclusion is entitled to diminished weight.

I also accord Dr. Crisalli's opinion as to the existence of pneumoconiosis diminished weight because of a similar reasoning flaw. Specifically, Dr. Crisalli based his diagnosis of no CWP, in part, on a lack of pathologic evidence of the disease. (DX 46 at 4). However, as described above, the record contains several pieces of positive pathologic evidence. Therefore, Dr. Crisalli's opinion is based, in part, on an assertion that does not reflect an accurate account of the record. Therefore, his opinion that the Claimant does not have pneumoconiosis is accorded diminished weight.

Conversely, I find the opinions of Drs. Perper and Rao both to be well-documented and well-reasoned. Both reference objective medical data in arriving at their respective conclusions, and explain how this evidence supports their conclusions, that the Claimant has pneumoconiosis. Therefore, because I credit the opinions of Drs. Perper and Rao, and both have found the presence of pneumoconiosis, I find that the medical report evidence supports the existence of pneumoconiosis.

I also find that the hospital and treatment records, as a whole, support the existence of pneumoconiosis. These records include the diagnosis of pneumoconiosis by several different physicians after a period of treatment. I note that these records also include the diagnosis of other conditions; however, I do not find that the presence of these other conditions tempers the diagnoses of pneumoconiosis.

Thus, in weighing all of the evidence together, as required by the Fourth Circuit, I find that the Claimant has established the existence of pneumoconiosis. Specifically, I find that the positive chest X-ray evidence, positive biopsy evidence, fully credited medical reports, and hospital records outweigh the negative chest X-ray evidence, CT scan evidence, negative biopsy evidence, and moderately discredited medical report evidence.

I note, however, that the type of pneumoconiosis the Claimant has established is both simple and clinical. Dr. Perper found the existence of complicated pneumoconiosis. However, in the wealth of medical evidence included in this record, there is no other evidence of complicated pneumoconiosis. Therefore, the evidence as a whole does not establish the existence of complicated pneumoconiosis.

Additionally, there exists some evidence in the record of legal pneumoconiosis; however, that evidence is insufficient to establish such a finding. Specifically, Dr. Perper found the presence of emphysema associated with coal dust exposure. However, because, amidst the voluminous medical evidence that exists in this case, there is no other evidence of emphysema due to coal dust exposure, I find that Dr. Perper's opinion is insufficient to establish that the Claimant had legal pneumoconiosis. The same is true with respect to Dr. Aubry's finding of interstitial pulmonary fibrosis associated with coal dust exposure; there is no other evidence of such a condition in the record. Thus, this reference is insufficient to establish the presence of legal pneumoconiosis. Finally, the records of Drs. Al-Asadi and Rao contain findings of COPD. However, there is no indication in their records that this COPD arose out of coal mine employment. Therefore, these references are also insufficient to establish the presence of legal pneumoconiosis.

Therefore, the Claimant has established the presence of pneumoconiosis, the first element of entitlement. However, I note that the type of pneumoconiosis the Claimant has established is simple and clinical.

D. Cause of Pneumoconiosis

If a miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten or more years in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Because the Claimant had in excess of ten years of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Additionally, the record does not contain contrary evidence that establishes that the Claimant's pneumoconiosis arose out of alternative causes.

E. Existence of Total Disability

As explained above, the Claimant must show that he has a totally disabling pulmonary or respiratory impairment. 20 C.F.R. § 718.204. Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevented him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony.

In this case, there is no evidence of cor pulmonale with right-side heart failure and all of the PFS tests are non-qualifying; therefore, the Claimant cannot establish total disability though those means.

However, the Claimant does establish the existence of a total disability based on blood gas and medical report evidence.

Initially, I note that I credit the evidence submitted in the current claim over the evidence submitted in the prior claim, based on recency.[35] In so finding, I particularly note the relatively long amount of time that passed between the development of the prior claim evidence and the current claim evidence.

As noted above, each physician who has offered a medical opinion in the current claim concluded that the Claimant is totally disabled.[36] Moreover, again as detailed above, these opinions are buttressed by the fact that both blood gas test administered after exercise produced qualifying values. I again find that this support for the existence of a total disability outweighs the countervailing evidence- namely the non-qualifying values of all PFS tests and at-rest blood gas tests, because of the unanimity of the medical opinion evidence, and its support from objective evidence of record.

Therefore, the Claimant has established the existence of a total disability, the third element of entitlement.

F. Cause of Total Disability

To establish disability causation, a miner must establish that he is totally disabled due to pneumoconiosis such that that disease is a "substantially contributing cause of the miner's totally

[35] *See Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993)(holding that more weight may be accorded to the results of recent blood gas evidence over earlier blood gas evidence); *Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984)(holding that more recent medical opinion evidence may be accorded weight over earlier medical opinion evidence).

[36] For the reasons stated above, I again find that Dr. Perper's report includes a finding of total disability.

disabling respiratory or pulmonary impairment." 20 C.F.R. § 718.204(c)(1)(2001).[37] Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

> (1) has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (2) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.
>
> 20 C.F.R. § 718.204(c)(1)(ii) & (ii).

The Fourth Circuit has interpreted this element to require that pneumoconiosis be a "contributing cause" of the miner's total disability. *Toler v. E. Assoc. Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995).

Additionally, because I have found that the Claimant has established the presence of pneumoconiosis, medical reports that conclude otherwise carry minimal weight as to disability causation. The Fourth Circuit has mandated as much, stating that in such circumstances:

> An [Administrative Law Judge] who has found (or assumed *arguendo*) that a claimant suffers from pneumoconiosis and has total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the [Administrative Law Judge] can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon her disagreement with the [Administrative Law Judge's] finding as to either or both of the predicates in the causal chain.

Scott v. Mason Coal Co., 289 F.3d 263, 269 (4th Cir. 2002); *Toler*, 43 F.3d at 115.

Moreover, the fact that a physician stated that his opinion concerning causation would not change even if the miner had pneumoconiosis, does not afford such an opinion additional credit. *See generally, Scott*, 289 F.3d at 268-270.

Based on the rule set forth in *Scott*, I credit the opinions of Drs. Gaziano, Rao, and Perper over the opinions of Drs. Crisalli and Zaldivar. Drs. Gaziano, Rao, and Perper all diagnosed pneumoconiosis while Drs. Crisalli and Zaldivar did not. Additionally, Drs. Gaziano, Rao, and Perper all attributed the Claimant's total disability to pneumoconiosis. (*see* CX 10; CX 12 at 1; DX 62 at 32). Conversely, Drs. Crisalli and Zaldivar both found the Claimant to be totally disabled, but stated that his disability was not due to pneumoconiosis. (*see* DX 46 at 5; EX 1 at 8). As I do not find any persuasive reasons for finding that the disability causation opinions of Drs. Crisalli and Zaldivar were not based on their finding of an absence of pneumoconiosis, their opinions are entitled to less weight than those of Drs. Gaziano, Rao, and Perper.

Therefore, because I credit the opinions of Drs. Gaziano, Rao, and Perper over the opinions of Drs. Crisalli and Zaldivar, and the former three doctors all found that the Claimant's

[37] The Amended version of this provision, as is true of all of § 718 save one sentence, applies to claims filed before and after January 19, 2001. 20 C.F.R. § 718.2 (2001).

total disability is due to his pneumoconiosis, the Claimant has established disability causation, the fourth element of entitlement.

G. Date of Entitlement

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis. 20 C.F.R. § 725.503. If no specific onset date is evidenced from the record, benefits will begin on the first day in the month in which the miner filed the claim. 20 C.F.R. § 725.503(b). Such is the case here. Therefore, the Claimant is entitled to benefits as of October 1, 2002.

ATTORNEY FEES

An application by the claimant's attorney for approval of a fee has not been received; therefore no award of attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365-725.366. A service sheet showing that service has been made upon all the parties, including the Claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the Claimant has established one element of entitlement previously adjudicated against him in the prior claim, namely the existence of a total disability. He has also established all four elements of entitlement- the existence of pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Therefore, the Claimant is entitled to benefits.

ORDER

It is hereby ORDERED that the claim of J.V.S. for benefits under the Act is GRANTED.

It is further ORDERED that the Employer, ARCH OF WEST VIRGINIA/APOGEE COAL COMPANY pay[38] to the Claimant, J.V.S., all benefits to which he is entitled under the

[38] 20 C.F.R. § 725.502(a)(1)(65 Fed. Reg. 80085, Dec. 20, 2000) provides "Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated."

Act commencing on October 1, 2002.[39]

A

RICHARD A. MORGAN

Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[40]
At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter **to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210**. *See* 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

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[39] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund (with interest) for the full amount of all such payments. 20 C.F.R. § 725.602(a).

If an employer does not pay benefits after the Director's initial determination of eligibility, it may be ordered to pay the beneficiary simple interest on all past due benefits (and attorney's fee) at a rate according to the Internal Revenue Code § 6621. 20 C.F.R. §§ 725.608(a) and 725.608(c).

[40] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).